Workers' Compensation Board

S12790297

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name EDWARD PITRE

WCB Case Number (JCN) G1292951 **Date of Injury** 02/27/2015

Claim Administrator Claim Number W0571595369 **Maintenance Type Code Date** 01/11/2024

WCB Received Date 01/11/2024

INSURER INFORMATION

FEIN xxxxx6505 **Insurer ID** W846505

CLAIM ADMINISTRATOR INFORMATION

Name POLICE, FIRE, SAN, CORR, CITY OF NY **FEIN** xxxxx6505

Claim Representative Name PAULA FELICIEN **Postal Code** 11201

Claim Representative Business Phone Number 7187245546

E-mail Address PFELICIE@LAW.NYC.GOV **Claim Admin ID** W846505

EMPLOYEE INFORMATION

First Name EDWARD **Middle Name/Initial**

Last Name PITRE **Suffix**

Date of Birth 02/28/1971

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx3271

BENEFITS

Overpayment Amount - Current

Benefits

Benefit Types
030 - Permanent Partial/Scheduled
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross		Weekly Net		Benefit Payment Issue Date	Amount Paid
					Effective Date	Amount	Effective Date	Amount		

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
030 - Permanent Partial/Scheduled	02/28/2015	04/23/2018	164	1	$699.47
050 - Temporary Total	02/28/2015	03/11/2019	139	0	$97,750.13
070 - Temporary Partial	12/08/2015	05/26/2019	92	2	$63,960.26

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$11,475.00	350 - Total Payments to Physicians	$803.00
370 - Total Other Medical	$26,597.34	450 - Total Pharmaceutical Costs	$965.65
460 - Total Physical Therapy Costs	$2,986.43		

Recoveries

Recovery Type	Amount

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

Workers' Compensation Board

S12165875

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name EDWARD PITRE

WCB Case Number (JCN) G1292951 **Date of Injury** 02/27/2015

Claim Administrator Claim Number W0571595369 **Maintenance Type Code Date** 07/15/2023

WCB Received Date 07/15/2023

INSURER INFORMATION

FEIN xxxxx6505 **Insurer ID** W846505

CLAIM ADMINISTRATOR INFORMATION

Name POLICE, FIRE, SAN, CORR, CITY OF NY **FEIN** xxxxx6505

Claim Representative Name PAULA FELICIEN **Postal Code** 11201

Claim Representative Business Phone Number 7187245546

E-mail Address PFELICIE@LAW.NYC.GOV **Claim Admin ID** W846505

EMPLOYEE INFORMATION

First Name EDWARD **Middle Name/Initial**

Last Name PITRE **Suffix**

Date of Birth 02/28/1971

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx3271

BENEFITS

Overpayment Amount - Current

Benefits

Benefit Types
030 - Permanent Partial/Scheduled
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross		Weekly Net		Benefit Payment Issue Date	Amount Paid
					Effective Date	Amount	Effective Date	Amount		

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
030 - Permanent Partial/Scheduled	02/28/2015	04/23/2018	164	1	$699.47
050 - Temporary Total	02/28/2015	03/11/2019	139	0	$97,750.13
070 - Temporary Partial	12/08/2015	05/26/2019	92	2	$63,960.26

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$11,475.00	350 - Total Payments to Physicians	$803.00
370 - Total Other Medical	$26,597.34	450 - Total Pharmaceutical Costs	$965.65
460 - Total Physical Therapy Costs	$2,986.43		

Recoveries

Recovery Type	Amount

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

WORKERS' COMPENSATION BOARD

S9603617

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name EDWARD PITRE

WCB Case Number (JCN) G1292951

Date of Injury 02/27/2015

Claim Administrator Claim Number W0571595369

Maintenance Type Code Date 08/20/2021

WCB Received Date 08/20/2021

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx6505

Insurer ID W846505

CLAIM ADMINISTRATOR INFORMATION

Name POLICE, FIRE, SAN, CORR, CITY OF NY

FEIN xxxxx6505

Claim Representative Name PAULA FELICIEN

Postal Code 11201

Business Phone Number 7187245546

Fax Number

E-mail Address PFELICIE@LAW.NYC.GOV

Claim Admin ID W846505

EMPLOYEE INFORMATION

First Name EDWARD

Middle Name/Initial

Last Name PITRE

Suffix

Date of Birth 02/28/1971

Employee ID Type S - Employee Social Security Number

Employee ID xxxxx3271

BENEFITS

Benefits

Benefit Types
030 - Permanent Partial/Scheduled
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross		Weekly Net		Benefit Payment Issue Date	Amount Paid
					Effective Date	Amount	Effective Date	Amount		

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
030 - Permanent Partial/Scheduled	02/28/2015	04/23/2018	164	1	$699.47
050 - Temporary Total	02/28/2015	03/11/2019	139	0	$97,750.13
070 - Temporary Partial	12/08/2015	05/26/2019	92	2	$63,960.26

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$11,475.00	350 - Total Payments to Physicians	$338.00
370 - Total Other Medical	$26,597.34	450 - Total Pharmaceutical Costs	$965.65
460 - Total Physical Therapy Costs	$2,986.43		

Recoveries

Recovery Type	Amount

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

WORKERS' COMPENSATION BOARD

S8196118

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name EDWARD PITRE

WCB Case Number (JCN) G1292951

Date of Injury 02/27/2015

Claim Administrator Claim Number W0571595369

Maintenance Type Code Date 08/20/2020

WCB Received Date 08/20/2020

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx6505

Insurer ID W846505

CLAIM ADMINISTRATOR INFORMATION

Name POLICE, FIRE, SAN, CORR, CITY OF NY

FEIN xxxxx6505

Claim Representative Name PAULA FELICIEN

Postal Code 11201

Business Phone Number 7187245546

Fax Number

E-mail Address PFELICIE@LAW.NYC.GOV

Claim Admin ID W846505

EMPLOYEE INFORMATION

First Name EDWARD

Middle Name/Initial

Last Name PITRE

Suffix

Date of Birth 02/28/1971

Employee ID Type S - Employee Social Security Number

Employee ID xxxxx3271

BENEFITS

Benefits

Benefit Types
030 - Permanent Partial/Scheduled
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross		Weekly Net		Benefit Payment Issue Date	Amount Paid
					Effective Date	Amount	Effective Date	Amount		

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
030 - Permanent Partial/Scheduled	02/28/2015	04/23/2018	164	1	$699.47
050 - Temporary Total	02/28/2015	03/11/2019	139	0	$97,750.13
070 - Temporary Partial	12/08/2015	05/26/2019	92	2	$63,960.26

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$11,475.00	350 - Total Payments to Physicians	$338.00
370 - Total Other Medical	$26,597.34	450 - Total Pharmaceutical Costs	$965.65
460 - Total Physical Therapy Costs	$2,986.43		

Recoveries

Recovery Type	Amount

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) PY-Payment Report

S6568718

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.
The Claim Administrator has made payment(s) as reflected in Benefits and/or Payments Section of this document.

Employee Name EDWARD PITRE

WCB Case Number (JCN) G1292951 **Date of Injury** 02/27/2015

Claim Administrator Claim Number W0571595369 **Maintenance Type Code Date** 05/24/2019

Claim Type L - Became Indemnity for Lost Time **WCB Received Date** 05/24/2019

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx6505 **Insurer ID** W846505

CLAIM ADMINISTRATOR INFORMATION

Name POLICE, FIRE, SAN, CORR, CITY OF NY **FEIN** xxxxx6505

Claim Representative Name PAULA FELICIEN **Postal Code** 11201

Business Phone Number 7187245546 **Fax Number**

E-mail Address PFELICIE@LAW.NYC.GOV **Claim Admin ID** W846505

Late Reason

EMPLOYEE INFORMATION

First Name EDWARD **Middle Name/Initial**

Last Name PITRE **Suffix**

Date of Birth 02/28/1971

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx3271

CLAIM INFORMATION

Date Employer Had Knowledge of Date of Disability 03/27/2015

Pre-existing Disability No

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S

Calculated Wage $2,597.80

Calculated Weekly Compensation Amount $808.65

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

Employment Status 1 - Regular/Full-time Employee

Number of Days Worked Per Week 5

Work Week Type

Wage Period 01 - Weekly

Denial Rescission Date

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation No

Type of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage 35.0% **Body Part** 33 - Lower Arm

Impairment Percentage 22.50% **Body Part** 35 - Hand

Death Result of Injury **Date of Death** **Number of Dependents** 9

Dependent/Payee Relationship

WORK STATUS

First Day of Disability After The Waiting Period 02/28/2015

Latest Return to Work Status Date 04/13/2015

Initial Date Disability Began 02/28/2015

Initial Return to Work Date 03/04/2015

Return To Work Type A - Actual **Physical Restrictions** No **Return To Work Same Employer** Yes

BENEFITS

Reduced Benefit Amount R - Reclassification of Benefit

Estimated Gross Weekly Amt.

Benefits

Benefit Types
030 - Permanent Partial/Scheduled
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
030	02/28/2015	04/23/2018	164	1	02/28/2015	$808.65	02/28/2015	$808.65	05/22/2019	$699.47
050	02/28/2015	03/11/2019	139	0	09/14/2015	$808.65	09/14/2015	$808.65	08/19/2018	$97,750.13

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
070 - Temporary Partial	12/08/2015	05/26/2019	92	2	$63,960.26

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$11,475.00	350 - Total Payments to Physicians	$338.00
370 - Total Other Medical	$25,998.82	450 - Total Pharmaceutical Costs	$965.65
460 - Total Physical Therapy Costs	$2,986.43		

PAYMENTS

Award/Order Date _____ **Lump Sum Payment/Settlement** AW - Award

Payment Reasons
030 - Permanent Partial/Scheduled
050 - Temporary Total

Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
030	EDWARD PITRE	02/28/2015	04/23/2018	05/22/2019	$699.47
050	EDWARD PITRE	04/24/2018	03/11/2019	05/22/2019	$9,560.36

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx6505 **Insured FEIN** xxxxx6505

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

WORKERS' COMPENSATION BOARD

S5598069

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name EDWARD PITRE

WCB Case Number (JCN) G1292951 **Date of Injury** 02/27/2015

Claim Administrator Claim Number W0571595369 **Maintenance Type Code Date** 08/20/2018

WCB Received Date 08/20/2018

INSURER INFORMATION

FEIN xxxxx6505 **Insurer ID** W846505

CLAIM ADMINISTRATOR INFORMATION

Name POLICE, FIRE, SAN, CORR, CITY OF NY **FEIN** xxxxx6505

Claim Representative Name PAULA FELICIEN **Postal Code** 11201

Business Phone Number 7187245546 **Fax Number**

E-mail Address PFELICIE@LAW.NYC.GOV **Claim Admin ID** W846505

EMPLOYEE INFORMATION

First Name EDWARD **Middle Name/Initial**

Last Name PITRE **Suffix**

Date of Birth 02/28/1971

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx3271

BENEFITS

Benefits

Benefit Types
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross		Weekly Net		Benefit Payment Issue Date	Amount Paid
					Effective Date	Amount	Effective Date	Amount		

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
050 - Temporary Total	02/28/2015	08/19/2018	109	4	$88,189.77

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
070 - Temporary Partial	12/08/2015	11/12/2017	52	2	$36,400.26

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$5,100.00	350 - Total Payments to Physicians	$338.00
370 - Total Other Medical	$25,840.99	450 - Total Pharmaceutical Costs	$965.65
460 - Total Physical Therapy Costs	$2,986.43		

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx6505

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

WORKERS' COMPENSATION BOARD

S3714160

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name EDWARD PITRE

WCB Case Number (JCN) G1292951

Date of Injury 02/27/2015

Claim Administrator Claim Number W0571595369

Maintenance Type Code Date 02/27/2017

WCB Received Date 02/27/2017

INSURER INFORMATION

FEIN xxxxx6505

Insurer ID W846505

CLAIM ADMINISTRATOR INFORMATION

Name POLICE, FIRE, SAN, CORR, CITY OF NY

FEIN xxxxx6505

Claim Representative Name PAULA FELICIEN

Postal Code 11201

Business Phone Number 7187245546

Fax Number

E-mail Address

Claim Admin ID W846505

EMPLOYEE INFORMATION

First Name EDWARD

Middle Name/Initial

Last Name PITRE

Suffix

Date of Birth 02/28/1971

Employee ID Type S - Employee Social Security Number

Employee ID xxxxx3271

BENEFITS

Benefits

Benefit Types
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross		Weekly Net		Benefit Payment Issue Date	Amount Paid
					Effective Date	Amount	Effective Date	Amount		

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
050 - Temporary Total	02/28/2015	03/05/2017	48	3	$38,700.39

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
070 - Temporary Partial	12/08/2015	07/20/2016	32	2	$21,900.26

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$4,900.00	370 - Total Other Medical	$13,957.53
450 - Total Pharmaceutical Costs	$965.65	460 - Total Physical Therapy Costs	$2,688.44

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx6505

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

WORKERS' COMPENSATION BOARD

F1824709

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 02-Change

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Pursuant to 12 NYCRR §300.22, when the claim administrator is changing the Denial Reason, this notice must be served on the claimant and his or her attorney or licensed representative, if any, within one business day of the date it is filed electronically with the chair.

Employee Name EDWARD PITRE

WCB Case Number (JCN) G1292951 **Date of Injury** 02/27/2015

Claim Administrator Claim Number W0571595369 **Maintenance Type Code Date** 03/02/2016

Claim Type L - Became Lost Time **WCB Received Date** 03/02/2016

INSURER INFORMATION

Insurer Name POLICE, FIRE, SAN, CORR, CITY OF NY **FEIN** xxxxx6505

Insurer Type S - Self-Insurer **Insurer ID** W846505

CLAIM ADMINISTRATOR INFORMATION

Name POLICE, FIRE, SAN, CORR, CITY OF NY

Info/Attn NYC LAw Department-Workers Compensation Divi

Address 350 JAY STREET

City BROOKLYN **State** NY

Postal Code 11201 **Country** US - UNITED STATES

FEIN xxxxx6505 **Claim Admin ID** W846505

Late Reason

FULL DENIAL REASONS

Full Denial Effective Date

Full Denial Reason

Denial Reason Narrative

F1824709

EMPLOYEE INFORMATION

First Name EDWARD **Middle Name/Initial**

Last Name PITRE **Suffix**

Mailing Address 130-59 115TH STREET

City SOUTH OZONE PAR **State** NY

Postal Code 11420 **Country** US - UNITED STATES

Phone Number **Gender** M - Male

Date of Birth 02/28/1971 **Date of Hire**

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx3271

Occupation Description COMMUNICATION ELECTRICIAN

CLAIM INFORMATION

Time of injury **Date Employer Had Knowledge of the Injury** 02/27/2015

Employment Status 7 - Other **Date Claim Administrator Had Knowledge of the Injury** 03/27/2015

Wage Period 01 - Weekly **Date Employer Had Knowledge of Date of Disability** 02/28/2015

Estimated Wage $2,597.80 **Number of Days Worked Per Week**

Work Week Type **Work Days Scheduled** (S-Scheduled N-Non Scheduled) S M T W T F S

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes **Employer Paid Salary in Lieu of Compensation** No

Death Result of Injury **Date of Death** **Number of Dependents** 9

Nature of Injury 49 - Sprain or Tear

Part of Body 31 - Upper Arm

Cause of Injury 27 - Fall, Slip or Trip Injury - From Liquid or Grease Spills

Type of Loss 01 - Traumatic Injury

Accident/Injury Description

I WAS INFORMED THAT WHILE WORKING ON L126, HE (MR.PITRE) ARRIVED AT THE POST ON WEST 158TH STREET AND AMSTERDAM AVENUE, AS HE DISMOUNTED THE VEHICLE

WORK STATUS

Initial Date Last Day Worked **Return To Work Type** A - Actual

Initial Date Disability Began 02/28/2015 **Physical Restrictions** No

Initial Return to Work Date 03/04/2015 **Return To Work Same Employer** Yes

ACCIDENT LOCATION AND WITNESSES

Premises X - Other

Organization Name

Street 158TH ST AND AMSTERDAM AVE **State** NY

City NEW YORK **Postal Code** 10032

County/Parish NEW YORK - New York **Country** US - UNITED STATES

Location Narrative 158TH ST AND AMSTERDAM AVE NEW YORK NY

Witnesses	Business Phone Number

MEDICAL TREATMENT

Initial Treatment 3 - Emergency Evaluation, Diagnostic Testing, and Medical Procedures

Managed Care Org.

Managed Care Org. ID

EMPLOYER INFORMATION

Name FIRE DEPARTMENT **Employer FEIN** xxxxx6505

Industry Code 921190 **UI Number**

Manual Classification 9410 - Municipal, Township, County Or State Employee Noc

Info/Attn

Mailing Address 9 METROTECH PLAZA 2ND FLOOR

City BROOKLYN **State** NY

Postal Code 11201 **Country** US - UNITED STATES

Physical Addr 9 METROTECH PLAZA 2ND FLOOR

City BROOKLYN **State** NY

Postal Code 11201 **Country** US - UNITED STATES

Contact Name MAUREEN SOMMA

Contact Business Phone Number 7189991845

F1824709

INSURED INFORMATION

Insured Name FIRE DEPARTMENT

Insured FEIN xxxxx6505

Insured Type S - Self-Insured

Insured Location ID 1586

Policy Number ID

Policy Effective Date

Policy Expiration Date

WORKERS' COMPENSATION BOARD

F1102358

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 00-Original

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name EDWARD PITRE

WCB Case Number (JCN) G1292951 **Date of Injury** 02/27/2015

Claim Administrator Claim Number W0571595369 **Maintenance Type Code Date** 04/09/2015

Claim Type M - Medical Only **WCB Received Date** 04/10/2015

INSURER INFORMATION

Insurer Name POLICE, FIRE, SAN, CORR, CITY OF NY **FEIN** xxxxx6505

Insurer Type S - Self-Insurer **Insurer ID** W846505

CLAIM ADMINISTRATOR INFORMATION

Name POLICE, FIRE, SAN, CORR, CITY OF NY

Info/Attn NYC Law Department-Workers Compensation Division

Address 350 JAY STREET

City BROOKLYN **State** NY

Postal Code 11201 **Country** US - UNITED STATES

FEIN xxxxx6505 **Claim Admin ID** W846505

Late Reason

EMPLOYEE INFORMATION

First Name EDWARD **Middle Name/Initial**

Last Name PITRE **Suffix**

Mailing Address 130-59 115TH STREET

City SOUTH OZONE PAR **State** NY

Postal Code 11420 **Country** US - UNITED STATES

Phone Number **Gender** M - Male

Date of Birth 02/28/1971 **Date of Hire**

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx3271

Occupation Description COMMUNICATION ELECTRICIAN

F1102358

CLAIM INFORMATION

Time of injury

Date Employer Had Knowledge of the Injury 02/27/2015

Employment Status 7 - Other

Date Claim Administrator Had Knowledge of the Injury 03/27/2015

Wage Period 01 - Weekly

Date Employer Had Knowledge of Date of Disability 03/27/2015

Estimated Wage $1,666.00

Number of Days Worked Per Week

Work Week Type

Work Days Scheduled (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation No

Death Result of Injury

Date of Death

Number of Dependents 9

Nature of Injury 49 - Sprain or Tear

Part of Body 31 - Upper Arm

Cause of Injury 27 - Fall, Slip or Trip Injury - From Liquid or Grease Spills

Type of Loss 01 - Traumatic Injury

Accident/Injury Description

I WAS INFORMED THAT WHILE WORKING ON L126, HE (MR.PITRE) ARRIVED AT THE POST ON WEST 158TH STREET AND AMSTERDAM AVENUE, AS HE DISMOUNTED THE VEHICLE

WORK STATUS

Initial Date Last Day Worked

Return To Work Type A - Actual

Initial Date Disability Began 03/19/2015

Physical Restrictions No

Initial Return to Work Date 03/04/2015

Return To Work Same Employer Yes

ACCIDENT LOCATION AND WITNESSES

Premises X - Other

Organization Name

Street 158TH ST AND AMSTERDAM AVE

State NY

City NEW YORK

Postal Code 10032

County/Parish NEW YORK - New York

Country US - UNITED STATES

Location Narrative 158TH ST AND AMSTERDAM AVE NEW YORK NY

Witnesses

Business Phone Number

MEDICAL TREATMENT

Initial Treatment 3 - Emergency Evaluation, Diagnostic Testing, and Medical Procedures

Managed Care Org.

Managed Care Org. ID

EMPLOYER INFORMATION

Name FIRE DEPARTMENT

Employer FEIN xxxxx6505

Industry Code 921190

UI Number

Manual Classification 9410 - Municipal, Township, County Or State Employee Noc

Info/Attn

Mailing Address 9 METROTECH PLAZA 2ND FLOOR

City BROOKLYN

State NY

Postal Code 11201

Country US - UNITED STATES

Physical Addr 9 METROTECH PLAZA 2ND FLOOR

City BROOKLYN

State NY

Postal Code 11201

Country US - UNITED STATES

Contact Name MAUREEN SOMMA

Contact Business Phone Number 7189991845

INSURED INFORMATION

Insured Name FIRE DEPARTMENT

Insured FEIN xxxxx6505

Insured Type S - Self-Insured

Insured Location ID 1586

Policy Number ID

Policy Effective Date

Policy Expiration Date

Employee Claim

5082111281

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: Edward Pitre (First / MI / Last) 2. Date of Birth: 02/28/1971

3. Mailing address: 130-59 115th Street Queens, NY 11420 (Number and Street/PO Box / City / State / Zip Code)

4. Social Security Number: 121-60-3271 5. Phone Number: (732) 801-0347 6. Gender: [x] Male [ ] Female

7. Will you need a translator if you have to attend a Board hearing? [ ] Yes [x] No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: NYC Fire Department 2. Phone Number: (718) 624-2370

3. Your work address: 9 Metro Tech Plaza, Brooklyn, NY 11201 (Number and Street / City / State / Zip Code)

4. Date you were hired: _____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness:

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? [ ] Yes [ ] No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? Wire Communication

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) [x] Full Time [ ] Part Time [ ] Seasonal [ ] Volunteer [ ] Other: _____

4. What was your gross pay (before taxes) per pay period? $ _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? [ ] Yes [✓] No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: 02/27/2015 2. Time of injury: _____

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

158st Amsterdam Street

4. Was this your usual work location? [ ] Yes [ ] No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

working

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

coming out of the fire truck and slipped on a mountain of ice on the sidewalk.

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

left wrist, left shoulder

YOUR NAME: Edward Pitre (First / MI / Last) DATE OF INJURY/ILLNESS: 02/27/2015

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☒ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☒ Yes ☐ No
If yes, notice was given to: Miguel Floreia ☒ orally ☒ in writing Date notice given: 2/27/2015

11. Did anyone see your injury happen? ☒ Yes ☐ No ☐ Unknown If yes, list names:
Felix Garcia (Co-worker)

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☒ Yes, on what date? 02/27/2015 ☐ No skip to Section F.
2. Have you returned to work? ☒ Yes ☐ No If yes, on what date? 03/5/2015 ☒ regular duty ☒ limited duty
3. If you have returned to work, who are you working for now? ☒ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? $ _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? 03/04/2015 ☒ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
☒ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
Name and address where you were first treated: Findling Surgical PC,
58-50 Catalpa Avenue Ridgewood, New York 11385 Phone Number: (718) 418-4263
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
Give the name and address of the doctor(s) treating you for this injury/illness:
Phone Number:
5. Do you remember having another injury to the same body part or a similar illness? ☒ Yes ☐ No
If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
1996 got hurt
6. Was the previous injury/illness work related? ☐ Yes ☐ No
If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: Edward Pitre Print Name: Edward Pitre Date: 3/13/15

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: 3/13/15

Print Name: Joseph A. Romano, ESQ Title: Attorney at Law

ID No., if any: R 481607 If Licensed Representative, License No.: _____ Expiration Date: ____/____/____